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IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR THE COUNTY OF MULTNOMAH

MARK STRAWN, On His Own Behalf, and
as Representative of a Class of Similarly
Situated Persons,

Case No. 9908-09080

Plaintiff,

THIRD AMENDED COMPLAINT

v.

(Breach of Express Contract; Breach of
Implied Covenant of Good Faith and Fair
Dealing; Declaratory Judgment; Deceit)

FARMERS INSURANCE COMPANY OF
OREGON, a Stock Insurance Company;
MID-CENTURY INSURANCE
COMPANY, a foreign corporation; and
TRUCK INSURANCE EXCHANGE, a
foreign corporation,

NOT SUBJECT TO MANDATORY
ARBITRATION

Defendants.

Plaintiff, Mark Strawn, on his own behalf and on behalf of all persons similarly situated, alleges:

FACTS COMMON TO ALL CLAIMS

1.

Defendant Farmers Insurance Company of Oregon is an Oregon corporation duly authorized to transact insurance and is in the business of providing motor vehicle liability insurance, inclusive of Personal Injury Protection ("PIP") benefits, to policyholders in Oregon.

2.

Defendant Mid-Century Insurance Company, is a foreign corporation duly authorized to transact insurance and is in the business of providing motor vehicle liability insurance, inclusive of Personal Injury Protection ("PIP") benefits, to policyholders in Oregon.

////

1 3.

2 Defendant Truck Insurance Exchange is a foreign corporation duly authorized to transact
3 insurance and is in the business of providing motor vehicle liability insurance, inclusive of
4 Personal Injury Protection ("PIP") benefits, to policyholders in Oregon.

5 4.

6 Defendant Farmers Group Inc. is the management company for Farmers Insurance
7 Company of Oregon, Mid-Century Insurance Company, and Truck Insurance Exchange, which
8 administered all of the claims processing of PIP claims for such insurers, employed the persons
9 and individuals making the PIP claims decisions described herein, and aided, abetted, and acted
10 in concert with such insurers in each of the acts and omissions described herein.

11 5.

12 Defendants Farmers Insurance Company of Oregon, Mid-Century Insurance Company
13 and Truck Insurance Exchange are affiliated insurance companies in that policies for each
14 insurer are sold through sales agents of defendant Farmers Insurance Group, each insurer
15 represents a different risk pool having differing rates of premium for "Farmers" policyholders,
16 and each is a subsidiary of the same corporation, BATUS.

17 6.

18 Plaintiff, Mark Strawn ("Strawn"), is an individual residing in Multnomah County,
19 Oregon, who at all times relevant herein was a motor vehicle insurance policyholder with
20 defendant Farmers Insurance Company of Oregon, Policy No. 73-12705-50-06.

21 7.

22 At all times relevant herein plaintiff's motor vehicle liability insurance policy with
23 defendant Farmers Insurance Company of Oregon contained personal injury protection ("PIP")
24 benefits. Class members, at all times relevant herein, were issued motor vehicle liability
25 insurance policies with defendants Farmers Insurance Company of Oregon, Mid-Century
26 Insurance Company, and Truck Insurance Exchange.

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8.

Plaintiff was injured in a motor vehicle collision on or about November 20, 1997 in Multnomah County, and, thereafter, on or about November 26, 1997, duly submitted an application for PIP benefits that was accepted by defendant Farmers Insurance Company of Oregon.

9.

On or about November 20, 1997, an emergency room physician providing medical services to plaintiff submitted a bill for \$35.00 for the reasonable cost of an x-ray exam of plaintiff's chest and spine, following a diagnosis of chest pain and cervicalgia. On or about November 21, 1997, a trauma hospital providing medical services to plaintiff submitted a bill for \$110.00 for the reasonable cost of providing a diagnosis of subarachnoid hemorrhage and coma, and on or about August 12, 1998 and September 16, 1998, a neuropsychologist providing medical services to plaintiff submitted a bill for \$1,387.50 for the reasonable cost of undertaking closed head injury testing following a diagnosis of chronic organic brain syndrome.

10.

Defendant Farmers Insurance Company of Oregon and Farmers Insurance Group, Inc. made direct payment to plaintiff's medical and hospital providers under PIP of approximately \$17,804 but reduced payment to plaintiff's emergency room physician by the amount of \$8.30, to the trauma hospital by the amount of \$7.00, and to plaintiff's neuropsychologist by the amount of \$412.50, all of which were charges necessarily incurred by plaintiff.

11.

Plaintiff did not receive payment or indemnification from defendant Farmers Insurance Company of Oregon and Farmers Insurance Group, Inc. or reimbursement for all reasonable and necessary medical and hospital expenses incurred as a result of injuries covered by PIP benefits.

12.

Defendant Farmers Insurance Company of Oregon and Farmers Insurance Group, Inc.

1 reduced payment of plaintiff's expenses upon its stated basis that the "charges exceeded an
 2 amount that would appear reasonable when the charges are compared to charges of other
 3 providers within the same geographic area." Defendant Farmers Insurance Company of Oregon
 4 and Farmers Insurance Group, Inc. did not reduce or refuse payment on the basis that such
 5 charges and services were unnecessary.

6 13.

7 At all times relevant herein the defendants' standard terms in its automobile liability
 8 policy Part III-No Fault contained the following provisions:

9 **Coverage D- Personal Injury Protection**

10 We will provide the benefits shown in the schedule for bodily injury to an insured
 11 caused by an accident arising out of the operation or use of a motor vehicle.

12 **Schedule of Personal Injury Protection Benefits**

(Coverage R1 applies to each insured person unless otherwise shown in
 Declarations)

Coverage Description	Limits of Liability			
	R1	R2	R3	R4
A. Medical Expense	See Declarations			
B. Funeral Expenses (Maximum)	\$250 0	\$2500	\$250 0	\$250 0
C. Loss of Income – Maximum Monthly Benefits	\$125 0	\$1250	\$125 0	\$150 0
D. Essential Services Expenses- Maximum Daily Benefits	\$30	\$30	\$30	\$30
E. Child Care Expenses- Maximum Daily Benefit	\$15	\$15	\$15	\$15

21 **A. Medical Expenses.**

22 We will pay for all expenses incurred within one year from the date of the accident
 23 which caused the injury.

24 **Additional Definitions Used In This Part Only**

25 **Medical Expense** means all reasonable and necessary expenses of medical hospital,
 26 dental, X-Ray services, ambulance services, drugs, artificial substitutes for parts of
 the body, eyeglasses and nursing services.

Personal Injury Protection Benefits means the benefits required by Sections
 742.520 and 742.524 O.R.S.

14.

Defendants were required, pursuant to ORS 742.520 to 742.544, to provide PIP benefits no less favorable than the provisions in ORS 742.524(a) ("PIP" statute) (previously ORS 743.805) which provides:

ORS 742.524 Contents of personal injury protection benefits; deductibles

(1) Personal injury protection benefits as required by ORS 742.520 shall consist of the following payments for the injury or death of each person:

(a) All reasonable and necessary expenses of medical, hospital, dental, surgical, ambulance and prosthetic services incurred within one year after the date of the person's injury, but not more than \$10,000 in the aggregate for all such expenses of the person. Expenses of medical, hospital, dental, surgical, ambulance and prosthetic services shall be presumed to be reasonable and necessary unless the provider is given notice of denial of the charges not more than 60 calendar days after the insurer receives from the provider notice of the claim for the services. At any time during the first 50 calendar days after the insurer receives notice of claim, the provider shall, within 10 business days, answer in writing questions from the insurer regarding the claim. For purposes of determining when the 60 day period provided by this paragraph has elapsed, counting of days shall be suspended if the provider does not supply written answers to the insurer within 10 days and shall not resume until the answers are supplied."

15.

Defendants, for each of their PIP claimants, made a business determination to deny and refuse to pay PIP benefits by not reimbursing their insureds, and insureds' medical providers, and plaintiff and plaintiff's medical providers, with the portion of necessary medical and hospital expenses that exceed its determination of the 80th percentile of rates for providers within a geographic area on the grounds that charges above such percentile were unreasonable, and on or about May 21, 1999 modified the level to the 90th percentile, and on or about July 31, 1999 modified the level to the 99th percentile.

16.

On or about March 26, 1999, plaintiff, pursuant to ORCP 32(H), provided defendants with the prelitigation notice required by law, and demanded that defendants correct the wrong alleged herein, but defendants have failed and refused to pay any expense that defendants contend is in excess the 80th percentile.

1 17.

2 The class herein has been certified, which consists of approximately 8,000 persons
3 insured with defendant who were entitled to PIP benefits from January 1997 to September 1999,
4 and is so numerous that joinder of all individual class members is impracticable.

5 18.

6 The court has certified there are common questions of law and fact to the class members,
7 including, but not limited to:

8 A. whether defendants' practice and policy of denying PIP benefits in excess of the 80th
9 percentile satisfies the statutory requirements in the PIP statute to pay "all reasonable . . .
10 expenses;"

11 B. whether all expenses by a medical or hospital provider which exceed defendants' 80th
12 percentile are unreasonable;

13 C. whether expenses by a medical or hospital provider that exceed defendants' 80th
14 percentile are reasonable due to factors expressly excluded from defendants' consideration, such
15 as the provider's qualifications, quality of care, or specific geographic location;

16 D. whether usual and customary expenses charged by a medical or hospital provider are
17 reasonable if in excess of the 80th and 90th percentile as determined by defendants;

18 E. whether defendants' business decision to reduce payment for expenses may be based
19 solely upon a designated statistical level;

20 F. whether in the presence of a timely notification to a provider of defendants' reduction
21 of payment, such expenses should be presumed reasonable in a dispute with its insured;

22 G. whether defendants must bear the burden of proving that a charge in excess of
23 defendants' 80th and 90th percentile is unreasonable;

24 H. whether defendants' statistical and geographic method for determining
25 reasonableness, absent an express opinion of unreasonableness by a qualified medical or hospital
26 provider with knowledge of usual and customary charges in the community, is reliable and

1 accurate basis for rejecting payment upon grounds of unreasonableness.

2 19.

3 The court has certified that the claims of the plaintiff are typical of the claims of the class
4 members because:

5 A. The class members and plaintiff were all persons having automobile policies with
6 defendants containing the same PIP language and subject to the same PIP statute;

7 B. The class members and plaintiff were all persons who submitted a claim for PIP
8 benefits that were accepted by defendants in or after 1997;

9 C. The class members and plaintiff were all persons who incurred medical and hospital
10 services the necessity of which was not disputed by defendants;

11 D. The class members and plaintiff were all persons who received reduced payment
12 direct payment or reimbursement from defendants of medical or hospital expenses under PIP for
13 a portion of such expenses;

14 E. The class members and plaintiff were all persons whose PIP benefits were reduced by
15 defendants for the stated reason that medical or hospital expenses exceeded the 80th percentile as
16 determined by defendants;

17 F. The class members and plaintiff were all persons who received reduced
18 reimbursement of medical or hospital expenses from defendants on the basis that any and all
19 expenses exceeding the 80th and 90th percentile of charges in a geographic were unreasonable;

20 G. The class members and plaintiff were all persons who received a total reduction in
21 PIP benefits of medical or hospital expenses from defendant in an amount less than \$2,000.

22 20.

23 The court has certified that the representative plaintiff will fairly and adequately protect
24 the interests of the class.

25 21.

26 The court has certified that class action treatment of the claims would be superior to other

1 available methods for the fair and efficient adjudication of this case as follows:

2 A. The claims of individual class members are insufficient in total amount, and the
3 interests involved, in view of the complexities of the issues and the expenses of litigation, to
4 make class wide relief the superior method of affording significant relief to the members of the
5 class;

6 B. The relief sought is partially in the form of declaratory relief with respect to the class
7 as a whole which would as a practical matter be dispositive of the interests of the other members
8 who are not parties to the adjudication, and is a superior method to prevent inconsistent and
9 varying adjudication of the claim incompatible with defendants' standard of conduct;

10 C. The questions of law and fact common to members of the class predominate over any
11 questions affecting only individual members due to the uniform application of defendants'
12 percentile determination of reasonableness in PIP claims when necessity of treatment is not in
13 dispute;

14 D. It is desirable to concentrate the litigation of claims in a single forum in that
15 defendants' PIP practices affect policyholders throughout the State of Oregon.

16 FIRST CLAIM – BREACH OF CONTRACT

17 22.

18 Plaintiff realleges paragraphs 1 through 21 and further alleges:

19 23.

20 Plaintiff and class members have performed all conditions precedent under their
21 insurance contracts with defendants in order to receive PIP benefits.

22 24.

23 Defendants breached their insurance contract with plaintiff and class members by failing to
24 pay all reasonable medical and hospital expenses incurred within one year of injury up to the limits
25 of the plaintiff and class member's PIP coverage.

26 /////

1 25.

2 The plaintiff class representative has filed proof of loss with defendants for medical and
3 hospital expenses more than six months prior to the filing of this action, and, accordingly, class
4 representative is entitled to reasonable attorney fees pursuant to ORS 742.061.

5 26.

6 As a direct result of defendants' conduct, acts and omissions, the plaintiff has been
7 damaged in the amount of \$427.80 by Farmers Insurance Company of Oregon and Farmers
8 Insurance Group, Inc., and class members have been damaged by defendants in an amount,
9 which upon information and belief, is reasonably estimated in the amount of \$1,500,000.

10 SECOND CLAIM – BREACH OF IMPLIED COVENANT OF GOOD FAITH AND FAIR
11 DEALING

12 (Count One – Tortious Breach)

13 27.

14 Plaintiff realleges paragraphs 1 through 26 and further alleges:

15 28.

16 The insurance contract between defendants and the plaintiff and class members contained
17 an implied covenant of good faith and fair dealing that required the defendants to perform the
18 insurance contract in a manner that would not defeat the reasonable expectations of the parties.

19 29.

20 Plaintiff and class members reasonably expected that defendants would not dispute the
21 reasonableness of medical and hospital services billed by providers at such provider's usual and
22 customary charge, and that the payment for such expenses would not be subject to reduction
23 below a uniform maximum amount or subject to a statistical maximum for cost containment as
24 pre-determined by defendants.

25 30.

26 Defendants intentionally breached the implied duty of good faith and fair dealing by

1 unilaterally refusing to pay for any and all medical and hospital expenses usually and
2 customarily charged by providers to plaintiff and class members that exceeded the 80th percentile
3 for such charges as determined by defendants.

4 31.

5 Defendants' wrongful conduct was intentionally done without lawful justification or
6 excuse, or was recklessly done in disregard of the financial welfare of plaintiff and class
7 members for which exemplary damages should be awarded in an amount to be determined at
8 trial.

9 (Count Two- Contractual Breach)

10 32.

11 Plaintiff realleges paragraphs 1 through 29 and further alleges:

12 33.

13 Defendants breached the implied duty of good faith and fair dealing by unilaterally
14 refusing to pay for any and all medical and hospital expenses usually and customarily charged by
15 providers to plaintiff and class members that exceeded the 80th percentile for such charges as
16 determined by defendants.

17 **THIRD CLAIM – DECLARATORY JUDGMENT**

18 34.

19 Plaintiff realleges paragraphs 1 through 33 and further alleges:

20 35.

21 Plaintiff and class members are persons interested under a written insurance agreement
22 with defendants whose rights and legal relations are affected by an interpretation and
23 construction of ORS 742.524(1)(a).

24 36.

25 A case and controversy exists between the plaintiff and class members, and the
26 defendants, in that plaintiff and class members contend that defendant's practice of refusing to

1 pay that portion of any and all medical and hospital services in excess of its determination of the
2 80th and 90th percentiles is in violation of the requirements, under ORS 742.524(1)(a) that a PIP
3 insurer pay all reasonable medical and hospital services, and defendants contend that its
4 statistical maximum supplies a cost containment limit to its statutory obligation to pay all
5 reasonable expenses under ORS 742.524(1)(a).

6 37.

7 Plaintiff and class members are entitled to a declaration that defendants' statistical policy
8 and practice of denying charges in excess of its determination of the 80th and 90th percentiles is a
9 violation of ORS 742.524(1)(a).

10 FOURTH CLAIM – DECEIT

11 38.

12 Plaintiff realleges paragraphs 1 through 37 and further alleges:

13 39.

14 Defendants intentionally represented to plaintiff and class members that it would pay for
15 all reasonable medical and hospital expenses incurred by its policyholder as a result of an
16 automobile accident.

17 40.

18 Plaintiff and class members reasonably relied upon defendants' representation by
19 incurring medical and hospital expenses usually and customarily charged by health providers as
20 a result of an automobile accident without questioning the medical or hospital provider, in
21 advance, about the statistical level of such charges.

22 41.

23 Defendants' representation was knowingly false in that defendants omitted to disclose
24 that they had imposed cost containment procedures upon medical and hospital expenses and
25 would not pay reasonable medical and hospital charges that exceeded their determination of the
26 80th percentile of charges.

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42.

Defendants further falsely represented to plaintiff and class members that the medical and hospital expenses were reduced because the amount charged exceeded an amount that was "reasonable" based upon a reduction at the 80th and 90th percentiles when compared to the same type of providers in the same community for the same service for the same year.

43.

In truth the defendants omitted that its system frequently failed to compare the same year, the same provider type, the same community, and the same service, in arriving at a determination of the 80th and 90th percentiles.

44.

Plaintiff and class members did not know of the falsity of defendants' misrepresentations and omissions.

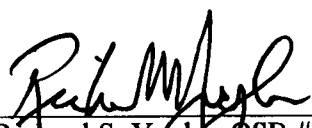
45.

As a direct and natural result of defendants' misrepresentation and omission, plaintiff and class members incurred medical and hospital expense in the amount previously alleged herein.

WHEREFORE, plaintiff and class members respectively pray for judgment in the approximate amount of \$1,500,000 on the first, second, and fourth claims for relief, a declaration on the third claim that defendants' policy and practice of denying any and all charges in excess of its determination of the 80th and 90th percentile of charges is a violation of ORS 742.524(1)(a), exemplary damages on plaintiff's second claim (count one), and fourth claim for relief in the amount of \$15,000,000, reasonable attorney fees for class members, costs and disbursements.

DATED this 12th day of November, 2003.

LANDYE BENNETT BLUMSTEIN LLP


Richard S. Yagler, OSB #80416
Of Attorneys for Plaintiff

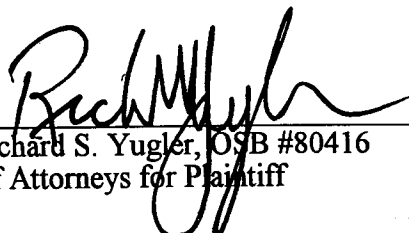
1 **CERTIFICATE OF SERVICE**

2 I hereby certify that on November 12, 2003, I served the foregoing **THIRD AMENDED**
3 **COMPLAINT** on the following individuals:

4 Michael D. Hoffman
5 Mark E. Olmsted
6 Hoffman Hart & Wagner
7 1000 SW Broadway, Suite 2000
8 Portland, OR 97207
9 *Of Attorneys for Defendants*

10 by hand delivery.

11 **LANDYE BENNETT BLUMSTEIN LLP**

12 
13 _____
14 Richard S. Yugler, OSB #80416
15 Of Attorneys for Plaintiff